be inspired
COUNSELING, LLC

Telehealth Consent to Treat

The purpose of the following is an agreement for consent to treat through Telehealth services.

I do hereby seek and consent to take part in Telehealth through Be Inspired Counseling, LLC. I understand that online counseling/Telehealth includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that Telehealth also involves the communication of my medical/mental information, both orally and visually. Be Inspired Counseling utilizes the following HIPAA secure platforms: Doxy.me and Zoom. ____

I acknowledge that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. ___

I understand that the laws that protect the confidentiality of my medical information also apply to online counseling/Telehealth. I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with Telehealth, just as there are with in-person therapy. I am in agreement with these limits/exceptions, and have a previously signed agreement on file regarding my understand of these. ____

I understand that there are risks and consequences from online counseling/Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures. I understand that if the Telehealth session does get disconnected, my therapist will call me back by phone, to complete our session. ____

I understand that although insurance reimbursement for Telehealth services may have been mandated during the COVID-19 pandemic, such mandates may no longer be in effect, and Telehealth may no longer be reimbursed or fully reimbursed by your insurance company. I understand that I will be responsible for any charges not covered. ___

In addition, I understand that online counseling/Telehealth based services and care may not be as complete as face-to-face services. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not be improve. ____

I know that if I am experiencing an emergency situation, I will continue to follow normal practice protocol, can call 911, and/or proceed to the nearest hospital emergency room for help. ___

I understand that I am responsible for (a) providing the necessary computer or telecommunications equipment and internet access for my Telehealth sessions, (b) using the Telehealth platform provided by Be Inspired Counseling, LLC, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my Telehealth session. ___

I acknowledge that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law, as outlined in the privacy practices provided to me at intake. ___

I have read, understand and agree to the information provided above. This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. Your signature below shows that you agree to these terms and conditions.

_____	_____
Client/Guardian Printed Name	Therapist Signature
_____	_____
Client/Guardian Signature	Date